REFERENCE TITLE: AHCCCS; ambulance services

State of Arizona
Senate
Forty-ninth Legislature
First Regular Session
2009

SB 1013

Introduced by
Senator Harper

AN ACT

AMENDING SECTIONS 36-2907, 36-2907.06, 36-2939 AND 36-2989, ARIZONA REVISED STATUTES; RELATING TO THE ARIZONA HEALTH CARE COST CONTAINMENT SYSTEM.

(TEXT OF BILL BEGINS ON NEXT PAGE)

Be it enacted by the Legislature of the State of Arizona:

Section 1. Section 36-2907, Arizona Revised Statutes, is amended to read:

36-2907. Covered health and medical services; modifications; related delivery of service requirements

A. Unless modified pursuant to this section, contractors shall provide the following medically necessary health and medical services:

1. Inpatient hospital services that are ordinarily furnished by a hospital for the care and treatment of inpatients and that are provided under the direction of a physician or a primary care practitioner. For the purposes of this section, inpatient hospital services ~~excludes~~ EXCLUDE services in an institution for tuberculosis or mental diseases unless authorized under an approved section 1115 waiver.

2. Outpatient health services that are ordinarily provided in hospitals, clinics, offices and other health care facilities by licensed health care providers. Outpatient health services include services provided by or under the direction of a physician or a primary care practitioner but do not include occupational therapy, or speech therapy for eligible persons who are twenty-one years of age or older.

3. Other laboratory and x-ray services ordered by a physician or a primary care practitioner.

4. Medications that are ordered on prescription by a physician or a dentist licensed pursuant to title 32, chapter 11. ~~Beginning January 1, 2006,~~ Persons who are dually eligible for title XVIII and title XIX services must obtain available medications through a medicare licensed or certified medicare advantage prescription drug plan, a medicare prescription drug plan or any other entity authorized by medicare to provide a medicare part D prescription drug benefit.

5. Emergency dental care and extractions for persons who are at least twenty-one years of age.

6. Medical supplies, equipment and prosthetic devices, not including hearing aids, ordered by a physician or a primary care practitioner or dentures ordered by a dentist licensed pursuant to title 32, chapter 11. Suppliers of durable medical equipment shall provide the administration with complete information about the identity of each person who has an ownership or controlling interest in their business and shall comply with federal bonding requirements in a manner prescribed by the administration.

7. For persons who are at least twenty-one years of age, treatment of medical conditions of the eye, excluding eye examinations for prescriptive lenses and the provision of prescriptive lenses.

8. Early and periodic health screening and diagnostic services as required by section 1905(r) of title XIX of the social security act for members who are under twenty-one years of age.

9. Family planning services that do not include abortion or abortion counseling. If a contractor elects not to provide family planning services,

this election does not disqualify the contractor from delivering all other covered health and medical services under this chapter. In that event, the administration may contract directly with another contractor, including an outpatient surgical center or a noncontracting provider, to deliver family planning services to a member who is enrolled with the contractor that elects not to provide family planning services.

10. Podiatry services performed by a podiatrist licensed pursuant to title 32, chapter 7 and ordered by a primary care physician or primary care practitioner.

11. Nonexperimental transplants approved for title XIX reimbursement.

12. MEDICALLY NECESSARY EMERGENCY ambulance ~~and nonambulance~~ transportation.

B. Beginning on October 1, 2002, circumcision of newborn males is not a covered health and medical service.

C. The system shall pay noncontracting providers only for health and medical services as prescribed in subsection A of this section and as prescribed by rule.

D. The director shall adopt rules necessary to limit, to the extent possible, the scope, duration and amount of services, including maximum limitations for inpatient services that are consistent with federal regulations under title XIX of the social security act (P.L. 89-97; 79 Stat. 344; 42 United States Code section 1396 (1980)). To the extent possible and practicable, these rules shall provide for the prior approval of medically necessary services provided pursuant to this chapter.

E. The director shall make available home health services in lieu of hospitalization pursuant to contracts awarded under this article. For the purposes of this subsection, "home health services" means the provision of nursing services, home health aide services or medical supplies, equipment and appliances, which are provided on a part-time or intermittent basis by a licensed home health agency within a member's residence based on the orders of a physician or a primary care practitioner. Home health agencies shall comply with the federal bonding requirements in a manner prescribed by the administration.

F. The director shall adopt rules for the coverage of behavioral health services for persons who are eligible under section 36-2901, paragraph 6, subdivision (a). The administration shall contract with the department of health services for the delivery of all medically necessary behavioral health services to persons who are eligible under rules adopted pursuant to this subsection. The division of behavioral health in the department of health services shall establish a diagnostic and evaluation program to which other state agencies shall refer children who are not already enrolled pursuant to this chapter and who may be in need of behavioral health services. In addition to an evaluation, the division of behavioral health shall also identify children who may be eligible under section 36-2901, paragraph 6, subdivision (a) or section 36-2931, paragraph 5 and shall refer the children

to the appropriate agency responsible for making the final eligibility determination.

G. ~~The director shall adopt rules for the provision of transportation services and rules providing for copayment by members for transportation for other than emergency purposes.~~ Prior authorization is not required for medically necessary ambulance transportation services rendered to members or eligible persons initiated by dialing telephone number 911 or other designated emergency response systems.

H. The director may adopt rules to allow the administration, at the director's discretion, to use a second opinion procedure under which surgery may not be eligible for coverage pursuant to this chapter without documentation as to need by at least two physicians or primary care practitioners.

I. If the director does not receive bids within the amounts budgeted or if at any time the amount remaining in the Arizona health care cost containment system fund is insufficient to pay for full contract services for the remainder of the contract term, the administration, on notification to system contractors at least thirty days in advance, may modify the list of services required under subsection A of this section for persons defined as eligible other than those persons defined pursuant to section 36-2901, paragraph 6, subdivision (a). The director may also suspend services or may limit categories of expense for services defined as optional pursuant to title XIX of the social security act (P.L. 89-97; 79 Stat. 344; 42 United States Code section 1396 (1980)) for persons defined pursuant to section 36-2901, paragraph 6, subdivision (a). Such reductions or suspensions do not apply to the continuity of care for persons already receiving these services.

J. Additional, reduced or modified hospitalization and medical care benefits may be provided under the system to enrolled members who are eligible pursuant to section 36-2901, paragraph 6, subdivision (b), (c), (d) or (e).

K. All health and medical services provided under this article shall be provided in the geographic service area of the member, except:

1. Emergency services and specialty services provided pursuant to section 36-2908.

2. That the director may permit the delivery of health and medical services in other than the geographic service area in this state or in an adjoining state if the director determines that medical practice patterns justify the delivery of services or a net reduction in transportation costs can reasonably be expected. Notwithstanding the definition of physician as prescribed in section 36-2901, if services are procured from a physician or primary care practitioner in an adjoining state, the physician or primary care practitioner shall be licensed to practice in that state pursuant to licensing statutes in that state similar to title 32, chapter 13, 15, 17 or 25 and shall complete a provider agreement for this state.

L. Covered outpatient services shall be subcontracted by a primary care physician or primary care practitioner to other licensed health care providers to the extent practicable for purposes including, but not limited to, making health care services available to underserved areas, reducing costs of providing medical care and reducing transportation costs.

M. The director shall adopt rules that prescribe the coordination of medical care for persons who are eligible for system services. The rules shall include provisions for the transfer of patients, the transfer of medical records and the initiation of medical care.

Sec. 2. Section 36-2907.06, Arizona Revised Statutes, is amended to read:

36-2907.06. Qualifying community health centers; contracts; requirements; definition

A. Subject to the availability of monies ~~as prescribed in section 36-2921~~, the administration shall enter into an intergovernmental agreement pursuant to title 11, chapter 7, article 3 with the department of health services to contract with qualifying community health centers to provide primary health care services to indigent or uninsured Arizonans. The department of health services shall enter into one year contracts with qualifying community health centers for the centers to provide the following primary health care services:

1. Medical care provided through licensed primary care physicians and licensed mid-level providers as defined in section 36-2171.

2. Prenatal care services.

3. Diagnostic laboratory and imaging services that are necessary to complete a diagnosis and treatment, including referral services.

4. Pharmacy services that are necessary to complete treatment, including referral services.

5. Preventive health services.

6. Preventive dental services.

7. Emergency services performed at the qualifying community health center.

8. MEDICALLY NECESSARY EMERGENCY transportation for patients to and from the qualifying community health center ~~if these patients would not receive care without this assistance~~.

B. Each contract shall require that the qualifying community health center provide the services prescribed in subsection A of this section to ~~persons~~ ANY PERSON who the center determines:

1. ~~Are residents~~ IS A RESIDENT of this state.

2. ~~Are~~ IS without medical insurance policy coverage.

3. ~~Do~~ DOES not have a family income of more than two hundred per cent of the federal poverty guidelines as established annually by the United States department of health and human services.

4. ~~Have provided~~ PROVIDES verification that the person is not eligible for enrollment in the Arizona health care cost containment system pursuant to this chapter.

5. ~~Have provided~~ PROVIDES verification that the person is not eligible for medicare.

C. The department of health services shall directly administer the program and issue requests for proposals for the contracts prescribed in this section. Contracts established pursuant to subsection A of this section shall be signed by the department and the contractor before the transmission of any tobacco tax and health care fund monies to the contractor.

D. Persons who meet the eligibility criteria established in subsection B or G of this section shall be charged for services based upon a sliding fee schedule approved by the department of health services.

E. In awarding contracts the department of health services may give preference to qualifying community health centers that have a sliding fee schedule. Monies shall be used for the number of patients that exceeds the number of uninsured sliding fee schedule patients that the qualifying community health center served during fiscal year 1994. Each qualifying community health center shall make its sliding fee schedule available to the public on request. The contract shall require the qualifying community health center to apply a sliding fee schedule to all of its uninsured patients.

F. The department of health services may examine the records of each qualifying community health center and conduct audits necessary to determine that the eligibility determinations were performed accurately and to verify the number of uninsured patients served by the qualifying community health center as a result of receiving tobacco tax and health care fund monies by the contract established pursuant to subsection A of this section.

G. Contracts established pursuant to subsection A of this section shall require qualifying community health center contractors to submit information as required pursuant to section 36-2907.07 for program evaluations.

H. For the purposes of this section, "qualifying community health center" means a community based primary care facility that provides medical care in medically underserved areas as provided in section 36-2352, or in medically underserved areas or medically underserved populations as designated by the United States department of health and human services, through the employment of physicians, professional nurses, physician assistants or other health care technical and paraprofessional personnel.

Sec. 3. Section 36-2939, Arizona Revised Statutes, is amended to read:

36-2939. Long-term care system services

A. The following services shall be provided by the program contractors to members determined to need institutional services pursuant to this article:

1. Nursing facility services other than services in an institution for tuberculosis or mental disease.

2. Notwithstanding any other law, behavioral health services if these services are not duplicative of long-term care services provided as of January 30, 1993 under this subsection and are authorized by the program contractor through the long-term care case management system. If the administration is the program contractor, the administration may authorize these services.

3. Hospice services. For the purposes of this paragraph, "hospice" means a program of palliative and supportive care for terminally ill members and their families or caregivers.

4. Case management services as provided in section 36-2938.

5. Health and medical services as provided in section 36-2907.

B. In addition to the services prescribed in subsection A of this section, the department, as a program contractor, shall provide the following services if appropriate to members who are defined as developmentally disabled pursuant to section 36-551 and are determined to need institutional services pursuant to this article:

1. Intermediate care facility for mental retardation services for a member who has a developmental disability as defined in section 36-551. For purposes of this article, such facility shall meet all federally approved standards and may only include the Arizona training program facilities, a state owned and operated service center, state owned or operated community residential settings or existing licensed facilities operated by this state or under contract with the department on or before July 1, 1988.

2. Home and community based services which may be provided in a member's home or an alternative residential setting as prescribed in section 36-591 or other behavioral health alternative residential facilities licensed by the department of health services and approved by the director of the Arizona health care cost containment system administration and which may include:

(a) Home health, which means the provision of nursing services or home health aide services or medical supplies, equipment and appliances, which are provided on a part-time or intermittent basis by a licensed home health agency within a member's residence based on a physician's orders and in accordance with federal law. Physical therapy, occupational therapy, or speech and audiology services provided by a home health agency may be provided in accordance with federal law. ~~Beginning on July 1, 1998,~~ Home health agencies shall comply with federal bonding requirements in a manner prescribed by the administration.

(b) Home health aide, which means a service that provides intermittent health maintenance, continued treatment or monitoring of a health condition and supportive care for activities of daily living provided within a member's residence.

(c) Homemaker, which means a service that provides assistance in the performance of activities related to household maintenance within a member's residence.

(d) Personal care, which means a service that provides assistance to meet essential physical needs within a member's residence.

(e) Developmentally disabled day care, which means a service that provides planned care supervision and activities, personal care, activities of daily living skills training and habilitation services in a group setting during a portion of a continuous twenty-four hour period.

(f) Habilitation, which means the provision of physical therapy, occupational therapy, speech or audiology services or training in independent living, special developmental skills, sensory-motor development, behavior intervention, and orientation and mobility in accordance with federal law.

(g) Respite care, which means a service that provides short-term care and supervision available on a twenty-four hour basis.

(h) MEDICALLY NECESSARY EMERGENCY transportation~~, which means a service that provides or assists in obtaining transportation for the member~~.

(i) Other services or licensed or certified settings approved by the director.

C. In addition to services prescribed in subsection A of this section, home and community based services may be provided in a member's home, in an adult foster care home as prescribed in section 36-401, in an assisted living home or assisted living center as defined in section 36-401 or in a level one or level two behavioral health alternative residential facility approved by the director by program contractors to all members who are not defined as developmentally disabled pursuant to section 36-551 and are determined to need institutional services pursuant to this article. Members residing in an assisted living center must be provided the choice of single occupancy. The director may also approve other licensed residential facilities as appropriate on a case by case basis for traumatic brain injured members. Home and community based services may include the following:

1. Home health, which means the provision of nursing services or home health aide services or medical supplies, equipment and appliances, which are provided on a part-time or intermittent basis by a licensed home health agency within a member's residence based on a physician's orders and in accordance with federal law. Physical therapy, occupational therapy, or speech and audiology services provided by a home health agency may be provided in accordance with federal law. ~~Beginning on July 1, 1998,~~ Home health agencies shall comply with federal bonding requirements in a manner prescribed by the administration.

2. Home health aide, which means a service that provides intermittent health maintenance, continued treatment or monitoring of a health condition and supportive care for activities of daily living provided within a member's residence.

3. Homemaker, which means a service that provides assistance in the performance of activities related to household maintenance within a member's residence.

4. Personal care, which means a service that provides assistance to meet essential physical needs within a member's residence.

5. Adult day health, which means a service that provides planned care supervision and activities, personal care, personal living skills training, meals and health monitoring in a group setting during a portion of a continuous twenty-four hour period. Adult day health may also include preventive, therapeutic and restorative health related services that do not include behavioral health services.

6. Habilitation, which means the provision of physical therapy, occupational therapy, speech or audiology services or training in independent living, special developmental skills, sensory-motor development, behavior intervention, and orientation and mobility in accordance with federal law.

7. Respite care, which means a service that provides short-term care and supervision available on a twenty-four hour basis.

8. MEDICALLY NECESSARY EMERGENCY transportation~~, which means a service that provides or assists in obtaining transportation for the member~~.

9. Home delivered meals, which means a service that provides for a nutritious meal containing at least one-third of the recommended dietary allowance for an individual and which is delivered to the member's residence.

10. Other services or licensed or certified settings approved by the director.

D. The amount of money expended by program contractors on home and community based services pursuant to subsection C of this section shall be limited by the director in accordance with the federal monies made available to this state for home and community based services pursuant to subsection C of this section. The director shall establish methods for the allocation of monies for home and community based services to program contractors and shall monitor expenditures on home and community based services by program contractors.

E. Notwithstanding subsections A, B, C and F of this section, no service may be provided that does not qualify for federal monies available under title XIX of the social security act or the section 1115 waiver.

F. In addition to services provided pursuant to subsections A, B and C of this section, the director may implement a demonstration project to provide home and community based services to special populations, including disabled persons who are eighteen years of age or younger, medically fragile, reside at home and would be eligible for supplemental security income for the aged, blind or disabled or the state supplemental payment program, except for the amount of their parent's income or resources. In implementing this project, the director may provide for parental contributions for the care of their child.

G. Subject to section 36-562, the administration by rule shall prescribe a deductible schedule for programs provided to members who are eligible pursuant to subsection B of this section, except that the administration shall implement a deductible based on family income. In determining deductible amounts and whether a family is required to have deductibles, the department shall use adjusted gross income. Families whose adjusted gross income is at least four hundred per cent and less than or equal to five hundred per cent of the federal poverty guidelines shall have a deductible of two per cent of adjusted gross income. Families whose adjusted gross income is more than five hundred per cent of adjusted gross income shall have a deductible of four per cent of adjusted gross income. Only families whose children are under eighteen years of age and who are members who are eligible pursuant to subsection B of this section may be required to have a deductible for services. For the purposes of this subsection, "deductible" means an amount a family, whose children are under eighteen years of age and who are members who are eligible pursuant to subsection B of this section, pays for services, other than departmental case management and acute care services, before the department will pay for services other than departmental case management and acute care services.

Sec. 4. Section 36-2989, Arizona Revised Statutes, is amended to read:

36-2989. Covered health and medical services; modifications; related delivery of service requirements

A. Except as provided in this section, ~~beginning on October 1, 2001,~~ health and medical services as defined in section 36-2907 are covered services and include:

1. Inpatient hospital services that are ordinarily furnished by a hospital for the care and treatment of inpatients, that are medically necessary and that are provided under the direction of a physician or a primary care practitioner. For the purposes of this paragraph, inpatient hospital services exclude services in an institution for tuberculosis or mental diseases unless authorized by federal law.

2. Outpatient health services that are medically necessary and ordinarily provided in hospitals, clinics, offices and other health care facilities by licensed health care providers. For the purposes of this paragraph, "outpatient health services" includes services provided by or under the direction of a physician or a primary care practitioner.

3. Other laboratory and x-ray services ordered by a physician or a primary care practitioner.

4. Medications that are medically necessary and ordered on prescription by a physician, a primary care practitioner or a dentist licensed pursuant to title 32, chapter 11.

5. Medical supplies, equipment and prosthetic devices.

6. Treatment of medical conditions of the eye, including eye examinations for prescriptive lenses and the provision of prescriptive lenses for members.

7. Medically necessary dental services.

8. Well child services, immunizations and prevention services.

9. Family planning services that do not include abortion or abortion counseling. If a contractor elects not to provide family planning services, this election does not disqualify the contractor from delivering all other covered health and medical services under this article. In that event, the administration may contract directly with another contractor, including an outpatient surgical center or a noncontracting provider, to deliver family planning services to a member who is enrolled with a contractor who elects not to provide family planning services.

10. Podiatry services that are performed by a podiatrist licensed pursuant to title 32, chapter 7 and that are ordered by a primary care physician or primary care practitioner.

11. Medically necessary pancreas, heart, liver, kidney, cornea, lung and heart-lung transplants and autologous and allogeneic bone marrow transplants and immunosuppressant medications for these transplants ordered on prescription by a physician licensed pursuant to title 32, chapter 13 or 17.

12. Medically necessary emergency ~~and nonemergency~~ transportation.

13. Inpatient and outpatient behavioral health services that are the same as the least restrictive health benefits coverage plan for behavioral health services that are offered through a health care services organization for state employees under section 38-651.

B. The administration shall pay noncontracting providers only for health and medical services as prescribed in subsection A of this section.

C. To the extent possible and practicable, the administration and contractors shall provide for the prior approval of medically necessary services provided pursuant to this article.

D. The director shall make available home health services in lieu of hospitalization pursuant to contracts awarded under this article.

E. Behavioral health services shall be provided to members through the administration's intergovernmental agreement with the division of behavioral health in the department of health services. The division of behavioral health in the department of health services shall use its established diagnostic and evaluation program for referrals of children who are not already enrolled pursuant to this article and who may be in need of behavioral health services. In addition to an evaluation, the division of behavioral health shall also identify children who may be eligible under section 36-2901, paragraph 6, subdivision (a) or section 36-2931, paragraph 5 and shall refer the children to the appropriate agency responsible for making the final eligibility determination.

F. The director shall adopt rules for the provision of MEDICALLY NECESSARY EMERGENCY transportation services for members. Prior authorization is not required for medically necessary ambulance transportation services

rendered to members initiated by dialing telephone number 911 or other designated emergency response systems.

G. The director may adopt rules to allow the administration to use a second opinion procedure under which surgery may not be eligible for coverage pursuant to this article without documentation as to need by at least two physicians or primary care practitioners.

H. All health and medical services provided under this article shall be provided in the geographic service area of the member, except:

1. Emergency services and specialty services.

2. The director may permit the delivery of health and medical services in other than the geographic service area in this state or in an adjoining state if it is determined that medical practice patterns justify the delivery of services or a net reduction in transportation costs can reasonably be expected. Notwithstanding section 36-2981, paragraph 8 or 11, if services are procured from a physician or primary care practitioner in an adjoining state, the physician or primary care practitioner shall be licensed to practice in that state pursuant to licensing statutes in that state that are similar to title 32, chapter 13, 15, 17 or 25.

I. Covered outpatient services shall be subcontracted by a primary care physician or primary care practitioner to other licensed health care providers to the extent practicable for purposes of making health care services available to underserved areas, reducing costs of providing medical care and reducing transportation costs.

J. The director shall adopt rules that prescribe the coordination of medical care for members and that include a mechanism to transfer members and medical records and initiate medical care.

K. The director shall adopt rules for the reimbursement of specialty services provided to the member if authorized by the member's primary care physician or primary care practitioner.